

## **Babysitting Basics**

### Registration Form / Medical Information / Release Form

Form MUST be returned before youth may participate in Babysitting Basics course and \$25 fee paid.

#### **PARTICIPANT INFORMATION**

Participant's Name \_\_\_\_\_  
Permanent Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Parent Phone During Class ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Preferred Nickname \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_  
Home Phone ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Grade in August \_\_\_\_\_

The fees for service will be used to off-set direct expenses and to support the 4-H Youth Development County Extension Program.

#### **MEDICAL EMERGENCY CONTACT INFORMATION**

##### Person to Contact First

Name \_\_\_\_\_  
Relation to Participant \_\_\_\_\_  
Daytime Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
E-mail \_\_\_\_\_  
Name of Family Doctor \_\_\_\_\_  
Name of Dentist \_\_\_\_\_

##### Backup Contact (Relative or Friend)

Name \_\_\_\_\_  
Relation to Participant \_\_\_\_\_  
Daytime Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
E-mail \_\_\_\_\_  
Office Number \_\_\_\_\_  
Office Number \_\_\_\_\_

#### **INSURANCE POLICY INFORMATION**

The above-named participant is covered by health insurance. ☐ Yes\*\* ☐ No\*

\* If no, initial this line stating that you do not have health insurance and are aware that Iowa State University/University Extension/4-H does not carry any health insurance for you. \_\_\_\_\_

\*\* If yes, provide the following information which is required by Iowa State University to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name \_\_\_\_\_ P.H.'s Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Relation to Participant \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Occupation \_\_\_\_\_  
P.H.'s Employer's Name/Address \_\_\_\_\_

Insurance Company Name \_\_\_\_\_  
Policy # \_\_\_\_\_ Plan # \_\_\_\_\_

... and justice for all  
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**HEALTH INFORMATION (Please Print)**

Does the child have any of the following conditions or a history of any of the following conditions? (**Check all that apply.**)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Bronchitis                              | <input type="checkbox"/> Fainting Spells                           |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Ear Infections                          | <input type="checkbox"/> Heart or cardio-vascular problems/disease |
| <input type="checkbox"/> Convulsions/seizure | <input type="checkbox"/> Hay Fever                               | <input type="checkbox"/> Chronic bone, muscle or joint injuries    |
| <input type="checkbox"/> Migraine headaches  | <input type="checkbox"/> Other condition(s): (Please list) _____ |  |

Allergies or reactions: (**Check all that apply.**)

- |   |   |   |                                 |                                  |
|---|---|---|---------------------------------|----------------------------------|
| <input type="checkbox"/> Aspirin                | <input type="checkbox"/> Penicillin           | <input type="checkbox"/> Dairy              | <input type="checkbox"/> Gluten | <input type="checkbox"/> Peanuts |
| <input type="checkbox"/> Insect bites or stings | <input type="checkbox"/> Ivy/oak/sumac toxins | <input type="checkbox"/> Other (list) _____ |                                 |                                  |

Is your child currently on any prescribed or over-the counter medication? (If so, please record the condition/ailment, name of medication, dosage, time(s) of day, prescribing physician.)

\_\_\_\_\_

\_\_\_\_\_

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Date of last tetanus shot (approximate if necessary): \_\_\_\_\_

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**TO BE READ AND SIGNED BY PARTICIPANT****BEHAVIOR EXPECTATIONS OF THE PARTICIPANT**

It is important to follow the directions of the adult leader(s) at all times. I understand that as a participant I have the responsibility to help make the activity a safe experience for everyone through my behavior and conduct. I also understand the danger of not following rules and directions and agree to follow them.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

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**TO BE READ AND SIGNED BY PARENT OR GUARDIAN**

I understand that my child must be healthy and reasonably fit in order to safely participate in 4-H recreation activities and that I will inform the program leader(s) of any medication, ailment, condition, or injury that may affect his/her ability to participate safely.

**MEDICAL EMERGENCY PARENTAL PERMISSION\***

The health history for my child is correct and complete to my knowledge. If an injury or other medical condition occurs or arises, I hereby give permission to the ISU Extension staff or volunteer to provide routine health care and seek emergency treatment including x-rays or routine tests. I agree to the release of any record necessary for treatment, referral, billing or insurance purposes. I understand that I am financially responsible for charges and hereby guarantee full payment to the attending physicians or health care unit. In the event of an emergency where I cannot decide for my child, I give permission to the physician/hospital selected by the ISU Extension staff or volunteer to secure and administer treatment for my child, including hospitalization. (\*If you cannot sign this section of the form for any reason, contact the Regional Extension Director regarding a legal waiver in order to attend and participate.)

\_\_\_\_\_initial \_\_\_\_\_date

**PUBLICITY/IMAGE/VOICE PERMISSION**

The Iowa State University Extension 4-H Program normally takes photographs, video, and/or tape recording of our programs. During activities, a photograph or video/audio recording may be taken of you or your child. Unless you request otherwise, your initial below will be considered permission for Iowa State University and the 4-H Program to photograph, film, audio/video tape, record and/or televise your image and/or voice or the image and/or voice of your child for use in any publications or promotional materials, in any medium now known or developed in the future without any restrictions. If you object to ISU using you or your child's image or voice in this manner, please notify the adult leader. \_\_\_\_\_initial \_\_\_\_\_date

**4-H ASSUMPTION OF RISK AND RELEASE OF LIABILITY (Please read carefully.)**

I give permission for \_\_\_\_\_ to participate in the 4-H program. I understand that 4-H project activities/events may involve certain risks of physical activity and possible injury and that Iowa State University and its 4-H program will provide each participant with reasonable care, but that ISU cannot guarantee that my child will remain free of injury. In addition, some 4-H projects including but not limited to: shooting sports, horse or livestock projects, water activities, and other sporting activities have a higher degree of risk. I nonetheless wish to have my child participate in the 4-H program and ASSUME the RISK of participating. I agree to RELEASE from LIABILITY, INDEMNIFY and HOLD HARMLESS the State of Iowa, the Board of Regents of the State of Iowa, ISU and ISU Extension and their officers, employees and agents (hereinafter the RELEASEES) from any and all claim and/or cause of action arising out of and related to any injury, loss, penalties, damage, settlement, costs or other expenses or liabilities that occur as a result of my child's participation in the 4-H program. This release, however, is not intended to release the above-mentioned RELEASEES from liability arising out of their sole negligence.

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

(Must be signed by the parent or guardian if the participant is under 18 years old)